

# Risk Management



## Managing Handoff Risk in Psychiatry

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This ongoing column is dedicated to providing information to our readers on managing legal risks associated with medical practice. We invite questions from our readers. The answers are provided by PRMS, Inc. ([www.prms.com](http://www.prms.com)), a manager of medical professional liability insurance programs with services that include risk management consultation, education and onsite risk management audits, and other resources to healthcare providers to help improve patient outcomes and reduce professional liability risk. The answers published in this column represent those of only one risk management consulting company. Other risk management consulting companies or insurance carriers may provide different advice, and readers should take this into consideration. The information in this column does not constitute legal advice. For legal advice, contact your personal attorney. Note: The information and recommendations in this article are applicable to physicians and other healthcare professionals so “clinician” is used to indicate all treatment team members.

### QUESTION

I work in a hospital and maintain a small private practice. As I prepare to travel to a professional association meeting, I noted that the hospital utilizes a structured system to give a report and assign responsibility of my

patients to a colleague during my absence. I have never before employed a similar “handoff” system in my private practice, and many private practitioners do not seem to do so, but I think it is a good idea. Is this a problem area in psychiatric practice?

Would utilizing a “handoff” system constitute sound risk management?

### ANSWER

Patient handoffs in hospitals have been referred to as “the Bermuda Triangle of healthcare”—a time during which “dangerous errors and oversights can occur in the gap when a patient is moved to another unit or turned over to a new nurse or doctor during a shift change.”<sup>1</sup>

While much of the focus has been on handoffs occurring in healthcare facilities, handoffs in the outpatient setting, or as the patient is being transferred between inpatient and outpatient care, are equally risk prone and thus merit consideration. It is important to recognize that any time more than one clinician is providing care, there will be some type of handoff that potentially sets the stage for communication errors.

Breakdowns in communication are a factor in most malpractice claims made against psychiatrists. They result in such things as errors or delays in diagnosis and claims of patient abandonment. By focusing attention on areas where such a breakdown is most likely to occur and developing internal systems to facilitate communication, psychiatrists can do a great deal to mitigate risk. The following is a discussion of frequent points of transition in patient care and recommendations to help reduce risk during handoffs.

**Handoffs between inpatient and outpatient care.** Patients in hospitals are typically seen by a number of physicians, one of whom may or may not be their own treating psychiatrist. Because of the number of providers involved, there is a high risk of failures in continuity of care between the inpatient and outpatient settings. “Patients seldom escape the hospital without changes to their drug regimen and often go home with more

medication than prior to admission.”<sup>2</sup> These medication changes may be confusing to patients and/or their caregivers and may result in adverse outcomes. One study showed that of the 19 percent of patients who had an adverse event following discharge from the hospital, “the majority related to medication management.”<sup>2</sup>

In addition to problems relating to medication, a study published in the September 2009 issue of the *Journal of General Internal Medicine* found significant numbers of patients being discharged with pending test results, the fact of which was not noted in the discharge summary. Even more problematic is the fact that when such results are obtained, “there are no accepted standards for who should receive those results and who is responsible for following up on them.”<sup>3</sup>

In spite of these obstacles, psychiatrists should take steps to obtain discharge information—either directly from the hospital or from the patient—and chart these efforts. Establish a checklist of the information you believe to be essential in every case and take the necessary steps to obtain that information. This may include the following:

- Dates of hospitalization and treatment provided
- Patient’s condition or functional status at discharge
- Information given to the patient and family
- Reconciled discharge medication regimen, with rationale for changes and reasons for new prescriptions
- Specific follow-up needs (e.g., appointments or procedures to be scheduled)
- Tests pending at discharge<sup>4</sup>

Try to see patients as soon as possible after discharge, and ask them to bring along any instructions and/or medication lists they received upon discharge.

**Handoffs between multiple physicians.** “The major concern when multiple physicians are involved in the care of a patient with a specialty condition is whether the appropriate physician is responsible for the patient and whether patient care is coordinated.”<sup>5</sup> This may be further complicated in psychiatry as primary care physicians (PCPs) manage many psychiatric conditions, thus leading to disagreement as to whether a patient is appropriately managed by the psychiatrist or the PCP. To avoid potential conflicts or confusion on the part of either physicians or the patient, consider the following:

- Upon receipt of a referral from another physician, make certain that you are told the purpose of the consultation and the expectations of the referring physician.
- If a patient does not keep the scheduled appointment, advise the referring physician.
- When preparing the report for the referring physician, reiterate your understanding of who is to assume the patient’s ongoing care.
- If in your evaluation of the patient you determine that the patient’s condition merits immediate attention, contact the referring physician so the situation may be discussed and a decision reached regarding who is to provide care and a treatment plan.
- Advise the patient with whom to follow up and in what time frame. Provide this information in writing to avoid any confusion on the part of the patient.

**Handoffs between treating psychiatrist and covering psychiatrist.** Psychiatrists who are asked to cover for another psychiatrist in his or her absence are often at a disadvantage, as they do not know the patient’s history or plans for ongoing

care. Patients themselves may not be the best historians, particularly if theirs is a complex illness, which may further complicate the situation.

On those rare occasions when you actually manage to get away from your practice for a few days, take the following steps to minimize potential problems:

- Discuss with covering psychiatrist(s) those patients about whom you have particular concerns or who might be expected to require treatment in your absence.
- Make certain that all dictation and/or EHR entry is up-to-date to give covering psychiatrists a clear picture of the patient’s current status.
- If any of your patients are hospitalized, advise the hospital of your intended absence and plans for coverage.

**Handoffs between covering psychiatrist and treating psychiatrist.** In the event that you have been called upon to provide care to another psychiatrist’s patient during his or her absence or while you were on call, provide the other physician with a written report of your activities to include the following:

- Contact you have had with the patient and/or treatment rendered
- Contact with other healthcare providers regarding the patient
- Prescriptions given and/or refilled
- Any recommendations for follow-up.

**Handoffs between psychiatrist and patient/family.** Medicine is becoming more and more complex, and at the same time, patients are being left to assume more responsibility for their own follow-up care due to such things as earlier discharge from hospitals and the refusal of insurance companies to pay

for certain care. One way in which to avoid having patients slip through the cracks is to involve them in the handoff process. "The patient and family are the only constant and are thus in a position to play a critical role in ensuring continuity of care."<sup>6</sup> Despite all that has been written about patient rights, many are still reluctant to "overstep their bounds" and question their psychiatrists. As such, it is important to take steps to actively engage patients. Some steps to consider toward this end are as follows:

- Provide written instructions for follow-up care specifically stating with whom and in what time frame. (Provide copies of this information to the patient's PCP to further memorialize your expectations regarding the patient's ongoing care.) Standardized forms may be helpful to save time for you and your staff and to minimize confusion on the part of the patient.
- Provide basic information regarding the patient's disease and types of treatment utilized. This will help prepare patients for the next steps. It will also help to involve the patient and the patient's family in the process, so they can be active participants and help to ensure that necessary treatment is obtained in a timely manner. The American Psychiatric Association's website, [www.psych.org](http://www.psych.org), has a section for the public that is an excellent source of information on psychiatric disorders and provides links for further reading.

In all treatment settings, there are obstacles or barriers in achieving successful handoffs of which psychiatrists should be cognizant. These include the physical setting, language barriers, methods of

communication, and timing/convenience of the handoff itself. The overall key is to standardize handoff communication procedures by finding system solutions to lessen the burden of trying to remember everything. Just as in the hospital setting, mnemonic tools, checklists, and technology solutions may be helpful.

For each type of handoff, establish the critical information to be obtained or conveyed and determine the most effective way to accomplish this task. Tools used in the hospital setting such as the Situation, Background, Assessment and Recommendation (SBAR) process<sup>6</sup> can be adapted to the outpatient setting. Whatever system is used, it should be something that can be readily incorporated into your individual practice and easily utilized by all members.

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## REFERENCES

1. Landro L. Hospitals combat errors at the handoff. *The Washington Post*. June 28, 2006. [www.washingtonpost.com/local/vitaly-davydov-of-montgomery-who-killed-psychiatrist-held-in-another-slaying/2011/10/21/gIQAf7064L\\_story.html](http://www.washingtonpost.com/local/vitaly-davydov-of-montgomery-who-killed-psychiatrist-held-in-another-slaying/2011/10/21/gIQAf7064L_story.html). Accessed February 14, 2013.
2. Bayley KB, Savitz LA, Rodriguez G., et al. Barriers associated with medication information handoffs. *Advances in Patient Safety: From Research to Implementation*. Volumes 1-4, Rockville, MD: Agency for Healthcare Research and Quality; 2005. <http://www.ahrq.gov/qual/advances>. Accessed November 7, 2012.
3. Were MC, Li X., Kesterson J., et al. Adequacy of hospital discharge summaries in documenting tests with pending results and outpatient follow-up providers. *J Gen Intern Med*. 2009;24(9):1002-1006.
4. Korc B., Landers SJ. Discharge missteps can take seniors back to hospital. *AMedNews*. 2010; 53 (4).
5. Swartztrauber K, Vickrey BG. Do neurologists and primary care physicians agree on the extent of specialty involvement of patients referred to neurologists? *J Gen Intern Med*. 2004;19:654-661.
6. Communication During Patient Hand-Over (2007, May 3). WHO Collaborating Centre for Patient Safety Solutions. Patient Safety Solutions: Vol. 1. Solution 3. Accessed November 7, 2012, from [www.who.int/patientsafety/solutions/patientsafety/PS-Solution3.pdf](http://www.who.int/patientsafety/solutions/patientsafety/PS-Solution3.pdf).

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